Santé / Bio-Behavioral Medical Clinics
REQUEST FOR PRIOR AUTHORIZATION

FAX (559) 437-1119 PHONE (559) 437-1123

SANTÉ COMMUNITY PHYSICIANS

Please check health plan:

☐ Community Care Health Plan

☐ United Healthcare Medicare Solutions: Group Retiree

Type of Request:

☐ URGENT

☐ STANDARD

TREATMENT AUTHORIZATION REQUEST ☐ **MD** ☐ **TH**

SERVICES REQUIRING PRIOR AUTHORIZATION (please check requested service)

☐ **Inpatient** - Mental Health/Psychiatric

☐ **Inpatient** - Substance Use Disorder (SUD)

☐ **Inpatient** - Mental Health/Residential Treatment

☐ **Inpatient** - Substance use disorder (SUD) transitional residential recover

☐ **Office Visit** - Mental Health (treatment, monitoring drug therapy, behavior analysis for autism and pervasive disorder)

☐ **Office Visit** - Substance Use Disorder (chemical dependency evaluation/counseling, medical treatment for withdrawal symptoms)

☐ **Outpatient** - Mental Health partial hospitalization, intensive treatment, Psychological/Neuropsychological testing, electroconvulsive therapy, transcranial magnetic stimulation, psychiatric observation for acute psychiatric crisis, treatment for PDD/autism delivered in patient home

☐ **Outpatient** - Substance day treatment, intensive outpatient treatment, medical management of withdrawal symptoms/detoxification, SUD partial hospitalization

PATIENT INFORMATION

Patient Name: Last First MI	**Date of Birth** (Mo/Day/Yr)
Insurance ID:	**BBMC Account #:**
Requesting Provider:	**TAX ID:**
Contact Person	**Telephone:** **Fax:**
Address:	**Diagnosis (ICD-10):**

ADDITIONAL TREATMENT REQUESTED: ☐ **Yes** ☐ **No**

Visit Frequency: ☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Other: _____

Retro Auth: ☐ Yes ☐ No

Initial DOS: _____ *(submit request prior to last visit or expiration date, whichever comes first)*

SUMMARY NOTES (include dates of service under last authorization)

TREATMENT PLAN FOR ADDITIONAL SESSIONS

Print Provider Name: _____

Provider Signature: **Date:**

CASE MANAGEMENT AUTHORIZATION and NOTES

Authorization #: _____ **Sessions Authorized:** _____

Effective Date: _____ **Expiration Date:** _____

Approval Signature: _____

Within 5 days before the actual date of service, provider MUST confirm that the member's health plan coverage is still in effect. With the exception of urgent requests, it is recommended that you do not schedule appointments prior to authorization approval. Emergency services do not require prior authorization and are reviewed retrospectively for necessity.This message is intended only for the use of the individual/entity to which it is addressed and may contain confidential information. If the reader of this message is not the intended recipient, you are hereby notified that any distribution is strictly prohibited.

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Main Line: (559) 437-1111

COMPLETE THIS FORM AND FAX TO: (559) 437-1119

EFFECTIVE JUNE 2017